

Division of Health Care Facilities

PRINTED: 11/05/2014  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  11/03/2014
NAME OF PROVIDER OR SUPPLIER  HERITAGE CENTER, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1026 MCFARLAND STREET MORRISTOWN, TN 37814			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on November 3, 2014, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

OSZ021

If continuation sheet 1 of 1